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Royal Australian College of General Practitioners

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Via email: Andrew.Alderdice@abtassoc.com.au

Dear Mr Alderdice,

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide feedback on the independent evaluation of the Coordinated Veterans' Care (CVC) Program. The RACGP is the voice of general practitioners (GPs) in our growing cities and throughout rural and remote Australia. As a national peak body representing over 40,000 members working in or towards a career in general practice, our core commitment is to support GPs from across the entirety of general practice to address the primary healthcare needs of the Australian population.

The RACGP is very supportive of the CVC model of care in the way it systematises complex care for patients, and encourages multidisciplinary team care, and improved care coordination. Further, the RACGP considers it to be a key example of a successful GP-led care coordination program and the College has highlighted the successful features of this model to other health funders, including Medicare, and would support its expansion to other at-risk patient cohorts.

While improvements can and should be made, any redesigned CVC program needs to continue to be facilitated by general practice and funded through bundled care payments that adequately cover the cost of care being provided. To this end, the comments provided below represent ways the RACGP considers the CVC program could be improved, made more sustainable and effective for a broader range of eligible Veterans.

Consultation discussion questions

1. What role does your profession play in delivering care coordination for DVA clients under CVC arrangements?

The CVC program operates out of general practices, with GPs' initial role as the identification and enrolment of eligible patients. Once a GP has enrolled a patient, they conduct a comprehensive needs assessment. The GP then develops a care plan in partnership with the patient and a nurse coordinator based on the needs assessment, which is managed by the nurse along with the patient's wider care team. GPs will be the providers of care for much of the care plan and provide referrals where care must be sought elsewhere. The GP will also be the primary care coordinator for any health conditions that fall outside those being addressed by the care plan.

2. What does best practice care coordination look like and how does your profession engage in delivering multidisciplinary care to patients with complex chronic health conditions?

GPs provide a unique set of health services in the community as patient advocates and stewards of the healthcare system. GPs take a holistic approach to providing care with consideration to the context of a patient's work, family, and community. GPs also provide information around preventive care as well as managing acute illness and provide for all of a patient's health needs, including physical and mental

health conditions. Coordination for patient care, facilitated in general practice is a core element of the RACGP Vision for General Practice.

Best practice coordination of patient care results in patients feeling informed, empowered and in control of their care. Holistic care coordination considers not only health interventions but is also inclusive of social services available within the community. Optimal care coordination is patient-centred and adapts to their needs. Safe and quality care is provided by coordinated care that is continuous, comprehensive, patient-centred and high quality without duplication or care that is fragmented or contradictory. Shared clinical records, recall and reminder systems and fit-for-purpose IT infrastructure are important enablers of best-practice care coordination.

GPs are the care coordinators in primary health care. They are ideally placed as a central point of contact for their patient's healthcare. By providing referrals and receiving patients back in the community on discharge from hospital they have a complete understanding of where the patient is receiving care, what care they have received and what has and has not worked. GPs' training allows them to provide care for all of a patient's health concerns across the lifespan and can continue to provide care where patients may be excluded from other services due to a limited scope of practice.

a. Any there any systemic barriers to multidisciplinary care coordination?

Case conferencing is a core element of care coordination between health professionals. However, there are currently significant practical limitations for case conferencing between GPs and the wider healthcare system. Due to significant demands on all health sectors combined with workforce shortages across many health professions, GPs and other health professionals struggle to allocate time for case conferences and further struggle to find time where schedules allow two or more health professionals to have a case conference.[1] Digital systems can also present barriers to case conferencing if services require specific platforms to be used or are unable to provide secure two-way communication to protect patient privacy and share health information.

3. How do practices establish CVC Program eligibility?

CVC eligibility is considered routinely by GPs as part of their treatment of currently serving and ex-serving patients. GPs generally assess a patient for CVC eligibility if they are over 70, affected by multiple chronic health or are a veteran patient of any age who affected by a mental health condition.

4. What are the key barriers and drivers of uptake in the CVC program for Veteran Gold and White Card holders?

The low indexation of the DVA fee schedule is seeing an increasing number of GP practices being unable to accept Veteran Cards. For many general practices the DVA fee schedule does not reflect the current cost of providing care. In these instances, practices privately bill their patients who can use Medicare rebates to reduce the cost of care while paying a gap fee. As the CVC program requires billing specific DVA numbers, Gold and White Card holders will need to attend a practice that accepts the Veteran Card in order participate in the CVC program. Unless indexation of the DVA fee schedule is increased, refusal of Veteran Cards will continue to limit the uptake of the CVC program.

The complex bureaucratic process to acquire a Veteran Card also limits the uptake of the CVC program. Some veterans feel unable to navigate DVA processes and give up, instead receiving care through Medicare, privately funded channels or not receiving care at all. Other veterans find it more straightforward to access care through alternate DVA processes such as Non-Liability Health Care

arrangements or claiming under the Military Rehabilitation and Compensation Act's streamlining procedures (where their condition is listed).

5. What are the strengths and challenges of the current model of care utilised by the CVC program?

The facilitation of the CVC program through general practices is a major strength. There are four core features of high-performing primary care services: first contact access for each need; long-term person (not disease) focused care; comprehensive care for most health needs; and coordinated care when it must be sought elsewhere. GPs are the only health professionals that are trained to deliver all four core features of primary care. General practice is also the most affordable part of our health system, reducing costs for both patients and the health system overall. General practice is a patient's first point of contact for their health needs and has ultimate oversight of patient care while they are in the community.

Continuing to provide the CVC program within general practices will lead to the effective delivery of comprehensive long-term and preventive care for the whole person, assessment and diagnosis of complex conditions and initiation, coordination and leadership of treatment plans in an affordable way.

RACGP members have reported the administrative burden in the CVC program to be a disincentive to participating in the program. Particularly, requirements for participation reviews every 90 days adds considerable workload to the patient's care regimen and are not an intuitive part of the GPs care plan.

The RACGP recommends simplifying and streamlining the CVC program's patient review and administrative requirements.

The RACGP has observed the development of DVA-only practices that focus purely on providing for the needs of veterans through the DVA system. General practices on the other hand interact with multiple funders and sectors within the health system. Providing care through a DVA-only lens has the potential to fragment care and compromise patient outcomes.

a. How could the CVC program be improved to strengthen care coordination and patient health outcomes?

RACGP Recommendations:

- **The CVC program should be expanded to include White Card holders aged 50+ with a chronic health condition that is not a mental health condition.**

  Under the current eligibility criteria, white card holders could only access the scheme for a physical chronic health condition if they also had a mental health condition. The Grosvenor evaluation found that the program took many years for savings to be achieved because the target group was already elderly Gold Card holders are aged 70+).[2] They were being identified too late in their lives for savings to be realised and participants died or entered residential aged care before savings were achieved.[2]

- **Enrolling patients earlier in their lives and disease progression would allow the CVC program to better manage chronic conditions in earlier stages**

  This would increase the likelihood that the condition's progression will be slowed, reducing mortality and patient complexity and leading to healthcare system savings and improved patient outcomes in the long term. The 50+ age group has been selected as the evidence indicates it is the age group where heart disease becomes the leading cause of death for permanent, reserve and ex-serving

males.[3] Being aged 50+ is also a risk factor for diabetes and Chronic Obstructive Pulmonary Disease (COPD) which along with health disease are conditions that the CVC program seeks to target.[2,4,5]

- **A GP-focused awareness-raising campaign**

  Early career GPs have reported a lack of visibility of the CVC program meaning they are unaware of this potential support for providing care to DVA patients. Therefore, the RACGP recommends any revised CVC program be accompanied by a GP-focused awareness-raising campaign.

- **Support practice nurses assist veterans in applying for Veteran Cards and other DVA-funded support for their health conditions.**

Administrative burdens are also felt by veterans who can struggle with the DVA application processes to receive their care. Practice nurses are well placed to assist and support patients in navigating the health system including bureaucratic processes. This is because practice nurses are highly educated and skilled, are excellent health promoters and patient advocates and build cumulative trust and long-lasting relationships with patients. RACGP members have recommended that practice nurses be supported to assist veterans in applying for Veteran Cards and other DVA-funded support for their health conditions. This should occur through dedicated funding for practice nurses to assist veterans with these processes,

6. What patient-centred measures could be used to capture appropriate health and well-being outcomes for the CVC program?

It is important to involve patients in the evaluation of health policies as part of a patient-centred approach to health and health policy. The RACGP is supportive of the use of patient-reported outcome/experience measures (PROMs/PREMs) to achieve this goal. PROMs and PREMs have also been well-documented to support clinician decision-making and shared care planning. They are a good indicator for overall patient outcomes; especially in those conditions marked by a person's level of health and wellbeing, rather than their risk of dying. The RACGP has published standards for patient feedback as part of the 5th edition standards for general practice that should be considered as part of the RACGP's feedback.

PREMs that should be used in the CVC program evaluation include:

- Patients feel they understand their condition/s and how they are being treated.
- Patients understand who they should see about specific health concerns.
- Patients know how to access support if their health conditions worsen.
- Patients can identify supports outside of the health setting.
- Patients do not feel stressed or confused about managing appointments, tests and treatment as part of their care plan.

a. Does the appropriateness of these measures differ for Gold and White Card participants?

Yes, White Card participants will be solely participating due to mental health conditions compared to Gold Card holders who may be participating due to a range of chronic health conditions. While Gold Card holders may need to access non-health supports for day-to-day living needs, supports that can help maintain social and emotional well-being may be more relevant for White Card holders as they can only access the CVC for mental health conditions.

The RACGP looks forward to contributing to further discussions about these proposed reforms. Please contact Ms Samantha Smorgon, National Manager – Funding and Health System Reform, on (03) 8699 0566 or via samantha.smorgon@racgp.org.au if you have any questions regarding this submission.

Yours sincerely

A/Prof Michael Clements
RACGP Vice President and Chair, RACGP Rural

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